Advanced Behavioral Medicine PC

I AUTHORIZE ADVANCED BEHAVIORAL MEDICINE (ABM), ITS AGENTS AND ITS EMPLOYEES TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME / MY CHILD TO THE RECIPIENT WHICH MAY INCLUDE ALCOHOL AND DRUG ABUSE TREATMENT; PSYCHOLOGICAL AND SOCIAL WORK COUNSELING; HIV OR AIDS OR ARC; COMMUNICABLE DISEASE OR INFECTIONS, INCLUDING SEXUALLY TRANSMITTED DISEASES, VENEREAL DISEASE, TUBERCULOSIS AND HEPATITIS; AND DEMOGRAPHIC INFORMATION; FOR THE PURPOSES, AND UNDER THE CONDITIONS DESIGNATED ON THIS FORM.

Completion of this document authorizes the disclosure and/or use of the individually identifiable health information, consistent with applicable State and Federal law. **Failure to provide *all* information requested may invalidate this Authorization.**

1. **Protected health information may be used or disclosed regarding the following patient.**

NAME: (Last) _____ (First) _____ (M.I.) _____

DATE OF BIRTH - _____ S.S. # - _____ (optional)

ADDRESS: (Street) _____ (City) _____ (State) _____ (Zip) _____

TELEPHONE: (day) (_____) _____ (evening) (_____) _____

2. _____ **is authorized to make the requested use or disclosure of my health information.**
(Facility to **RELEASE** information)

ADDRESS: (Street) _____ (City) _____ (State) _____ (Zip) _____

PHONE: (_____) _____ FAX: (_____) _____

3. RECORDS DEPOSITION SERVICE **is authorized to receive my Protected Health Information.**
(Facility to **RECEIVE** information)

ADDRESS: (Street) P.O. BOX 5054 (City) SOUTHFIELD (State) MI (Zip) 48086-5054

PHONE: (248) 357-3330 FAX: (248) 357-3337

I AUTHORIZE MY INFORMATION TO BE FAXED TO THE ABOVE RECIPIENT. _____
(Patient, Parent, or Legal Representative Signature)

INFORMATION TO BE RELEASED:

- O Psychiatric Evaluation: From _____
- O Clinical Assessment: From _____
- O Psychotherapy/Progress Notes: From _____ to _____
- O Medication History: From _____ to _____
- O Laboratory Tests/Results: From _____ to _____
- O **All of the Above Information**
- O Billing information: From _____ to _____
- X **OTHER** (specific): ENTIRE MEDICAL FILE

PURPOSE FOR RELEASING INFORMATION:

- O At the Request of the Patient
- O Continuation of Care/Consultation
- O Social Security/Disability Certification
- O Attorney Inquiry/Legal Matter
- O Insurance Claim/Application
- O Worker's Compensation
- X **OTHER** (specify): PRE-TRIAL DISCOVERY
- O Phone Contact Only - **(COPIES WILL NOT BE SENT)**

Date Authorization expires: _____ (may be a specific date or a condition; if no expiration date or condition is listed, this release will expire 6 months from date signed)

SIGNATURE: _____ **DATE:** _____
(Patient)

SIGNATURE: _____ _____ **DATE:** _____
(Parent, Guardian, or Legal Representative) **(Relation to Patient Required)**

REVOCATION: I understand that I may revoke my authorization by writing to; Advanced Behavioral Medicine, 2901 E. Grand River, Howell, MI 48843. After it is revoked, ABM will make no further disclosures to the above persons without a new authorization. ABM can rely on this authorization until it is revoked, or until the expiration date or conditions are met. A request to revoke my authorization will not apply to the extent ABM has taken action in reliance upon my authorization. In the event that the authorization was obtained as a condition of providing insurance coverage, the revocation will not apply to my insurance company to the extent that the law provides my insurer with the right to contest a claim under the policy, or the policy itself. **REDISCLOSURE:** Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws. **CONDITIONING OF ELIGIBILITY:** ABM will not condition treatment, payment, enrollment, or benefit eligibility on my signing this document.